### Table 2.B1—Federal benefit rates, by living arrangement, 1974–2010

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<th>Act</th>
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<td>1974</td>
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(Continued)
2.65

CONTACT: Sherry Barber (410) 965-9851 or supplement@ssa.gov.


NOTE: For those in another person’s household receiving support and maintenance there, the federal benefit rate is reduced by one-third.

a. For those without countable income. These payments are reduced by the amount of countable income of the individual or couple.
b. Includes persons in private institutions whose care is not provided by Medicaid.
c. Superseded by the provision of 1973.
d. Mechanism established for providing cost-of-living adjustments.
e. General benefit increase.
f. Benefits originally paid in 2000 and through July 2001 were based on federal benefit rates of $512 and $530, respectively. Pursuant to Public Law 106-554, monthly payments beginning in August 2001 were effectively based on the higher $531 amount. Lump-sum compensation payments were made on the basis of an adjusted benefit rate for months prior to August 2001.
g. Must be receiving more than 50 percent of the cost of the care from Medicaid (Title XIX of the Social Security Act).

CONTACT: Sherry Barber (410) 965-9851 or supplement@ssa.gov.
Table 2.C1—Medicare cost sharing and premium amounts, 1966–2011 a

<table>
<thead>
<tr>
<th>Effective date b</th>
<th>Hospital Insurance (Medicare Part A)</th>
<th>Supplementary Medical Insurance (Medicare Parts B and D)</th>
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<td></td>
<td>Inpatient hospital deductible (IHD) covers</td>
<td>Part B</td>
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<tr>
<td></td>
<td>Days 61 through 90</td>
<td>Lifetime reserve days</td>
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<tr>
<td></td>
<td>(1/4 x IHD)</td>
<td>(1/2 x IHD)</td>
</tr>
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<td>1966</td>
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<td>2004</td>
<td>876</td>
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(Continued)
### Table 2.C1—Medicare cost sharing and premium amounts, 1966–2011—Continued

<table>
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<th>Effective date</th>
<th>Inpatient hospital deductible (IHD) covers first 60 days</th>
<th>Inpatient hospital daily coinsurance</th>
<th>Skilled nursing facility daily coinsurance</th>
<th>Out-of-pocket costs</th>
<th>Base beneficiary monthly premium (dollars)</th>
<th>Government amounts for—</th>
<th>Part B</th>
<th>Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Days 61 through 90 (1/4 x IHD)</td>
<td>Lifetime reserve days 90 through 100 (1/2 x IHD)</td>
<td>Monthly deductible (dollars)</td>
<td>Coinsurance (percent)</td>
<td>For enrollees aged and disabled (dollars)</td>
<td>Aged (dollars)</td>
<td>Disabled (dollars)</td>
<td>Initial coverage limit (dollars)</td>
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<td>912</td>
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<td>456</td>
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<td>238</td>
<td>476</td>
<td>119.00</td>
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<td>85.40</td>
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<td>2007</td>
<td>992</td>
<td>248</td>
<td>496</td>
<td>124.00</td>
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<td>2008</td>
<td>1,024</td>
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<td>512</td>
<td>128.00</td>
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<td>96.40</td>
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<td>2010</td>
<td>1,100</td>
<td>275</td>
<td>550</td>
<td>137.50</td>
<td>461</td>
<td>155</td>
<td>20</td>
<td>10.50</td>
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<td>2011</td>
<td>1,132</td>
<td>283</td>
<td>566</td>
<td>141.50</td>
<td>450</td>
<td>162</td>
<td>20</td>
<td>114.50</td>
</tr>
</tbody>
</table>

**SOURCE:** Centers for Medicare & Medicaid Services.

**NOTES:** The structure of Medicare has become increasingly complex over the years. This table provides a summary of Medicare cost sharing and premium provisions. It should be used as an overview and general guide. It is not intended to explain fully all of the provisions or exclusions of the applicable Medicare laws, regulations, and rulings. Original sources of authority should be consulted for specific details.

Values for certain 2011 premiums, copayments, and out-of-pocket thresholds not shown in the table are provided in footnotes as applicable. Corresponding values for prior years are available in previous editions of this table.

---

a. As of November 1, 2010.
b. Deductible and coinsurance amounts begin in January unless otherwise noted. Monthly premium amounts took effect in July through 1983 and in January beginning in 1984.
c. Enrollment in Part D is voluntary. Substantial premium and cost-sharing subsidies and waivers are available for Part D beneficiaries who meet certain low-income and limited-resources criteria. Subsidy levels vary.
d. Standard premium rate for voluntary enrollment by certain aged and disabled individuals not otherwise entitled to Hospital Insurance (HI). (Most individuals aged 65 and older and many disabled individuals aged 65 or older are insured for HI benefits without payment of any premium.) Beginning in 1994, a reduced premium is available to premium-paying HI enrollees with at least 30 quarters of Medicare-covered employment (either their own or through a current or former spouse if the marriage meets certain duration criteria). In most cases, a surcharge applies for beneficiaries who enroll after their initial enrollment period.
e. Most services under Part B are subject to the annual deductible and coinsurance percentages shown. Some noteworthy exceptions are footnoted; others include (1) clinical lab tests, home health agency services, and certain prescribed preventive care services, which are not subject to the deductible or coinsurance and for which the beneficiary pays nothing; (2) outpatient psychiatric services, for which the coinsurance is 50 percent but phases down to 20 percent over the 5-year period 2010–2014; and (3) most services reimbursed under the outpatient hospital prospective payment system, for which the coinsurance percentage varies by service but currently falls in the range of 20 percent to 50 percent.
f. Under the standard Part D benefit design, the beneficiary pays an initial deductible and 25 percent of the remaining costs until reaching the initial coverage limit. Between the initial coverage limit and the out-of-pocket threshold is a “coverage gap.” Beneficiaries in the coverage gap paid the full cost of their prescription drugs from 2006 to 2009. For 2010, beneficiaries in the coverage gap (excluding those low-income enrollees eligible for cost-sharing subsidies) received a $250 rebate, and for 2011, these beneficiaries will receive a 50 percent discount on covered brand-name prescription drugs and a 7 percent discount on covered generic drugs. In determining out-of-pocket costs, costs reimbursed through insurance are not counted toward the out-of-pocket threshold, except for cost-sharing assistance provided to low-income enrollees by Part D and State Pharmacy Assistance programs and, starting in 2011, the 50 percent discount on brand-name drugs purchased by enrollees in the Part D coverage gap. For costs incurred after the out-of-pocket threshold is reached, “catastrophic coverage” requires enrollees to pay the greater of a 5 percent coinsurance or a small copayment for 2011, $2.50 for generic or preferred multi-source drugs and $6.30 for other drugs). Many Part D plans differ from this standard coverage design; in fact, the majority of beneficiaries are enrolled in plans with low or no deductibles, flat payments for covered drugs, and, in some cases, additional partial coverage in the coverage gap.
g. The Part D premiums paid by individual beneficiaries equal the base beneficiary premium adjusted by a number of factors. Premiums vary significantly from one plan to another and seldom equal the base beneficiary premium. The estimated average monthly premium for 2011, as calculated and announced prior to the start of the year (based on the bids submitted by Part D plans, the specific plan-by-plan premiums, and the estimated number of beneficiaries in each plan) is $30. A surcharge for enrollment after the initial enrollment period may apply.
h. Represents standard premium for voluntary enrollment in Part B. This is the amount paid by most beneficiaries in most years (2010 and 2011 are notable exceptions). Three factors can alter the premium paid by a beneficiary: enrollment after the initial enrollment period, for which a surcharge may apply; adjustments for beneficiaries whose income is above certain thresholds; and a “hold-harmless” provision that prohibits Part B premium increases that exceed the dollar amount of a beneficiary’s Social Security cost-of-living adjustment. See also footnotes u, w, and x.
i. Professional inpatient services of pathologists and radiologists not subject to deductible or coinsurance, beginning in April 1968.
j. Beginning in April 1968.
k. Home health services not subject to coinsurance, beginning in January 1973.
l. Standard monthly premiums for July and August 1973 were reduced to $5.80 and $6.10, respectively, by the Cost of Living Council.
m. Home health services not subject to deductible, beginning July 1, 1981.
n. Professional inpatient services of pathologists and radiologists not subject to deductible or coinsurance, but only when physician accepts assignment.
o. Effective October 1, 1982, professional inpatient services of pathologists and radiologists are subject to deductible and coinsurance.
Table 2.C1—Medicare cost sharing and premium amounts, 1966–2011

p. The 1989 deductible was applied on an annual basis rather than a benefit-period basis. Once the beneficiary paid the deductible, Medicare paid the balance of expenses for covered hospital services, regardless of the number of days of hospitalization (except for psychiatric hospital care, which was still limited to 190 days).

q. In 1989 the coinsurance amount was equal to 20 percent of the estimated national average daily cost of covered skilled nursing facility care, the beneficiary paid the coinsurance amount for the first 8 days of care during the year, and benefits were available for up to 150 days of care during the year.

r. Includes the standard monthly Part B premium and a supplemental monthly flat premium under the Medicare Catastrophic Coverage Act of 1988. Persons enrolled in Part B only and residents of Puerto Rico and other territories and commonwealths paid lower supplemental flat premiums.

s. A temporary Medicare-endorsed prescription drug discount card program was offered. See the Medicare section of “Program Descriptions and Legislative History” (page 54 in this Supplement).

t. The 2011 out-of-pocket threshold of $4,550 is equivalent to total covered drug costs ranging from $6,447.50 to $6,719.03, depending on the percentage of brand-name versus generic drugs used by the beneficiary while in the coverage gap. See previous editions of this table for prior years’ equivalent total covered drug costs.

u. See footnote h. The 2011 Part B income-related monthly adjustment amounts and total monthly premium amounts to be paid by beneficiaries, according to income level and filing status, are shown in the Medicare section of “Program Descriptions and Legislative History” (page 41 in this Supplement).

v. For beneficiaries paying an income-related adjustment, the government amounts are to be reduced accordingly. See also footnotes h and u.

w. Most Part B enrollees are protected by a “hold-harmless” provision prohibiting Part B premium increases that exceed the dollar amount of an individual’s Social Security cost-of-living adjustment (COLA). Because the 2010 COLA equaled 0 percent, about 73 percent of Part B enrollees continued to pay the 2009 premium amount in 2010.

x. See footnote w. Because the 2011 COLA again equals 0 percent, most Part B enrollees will continue to pay the same premium amount they paid in 2010.

y. See footnote g. The 2011 Part D income-related monthly adjustment amounts to be paid by beneficiaries, according to income level and filing status, are shown in the Medicare section of “Program Descriptions and Legislative History” (page 42 in this Supplement).

CONTACT: John Shatto (410) 786-0706 or supplement@ssa.gov.
Table 2.C2—Federal medical assistance percentage and enhanced federal medical assistance percentage, by state or other area, 2009–2011

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<th>State or area</th>
<th>Federal medical assistance percentage</th>
<th>Enhanced federal medical assistance percentage</th>
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<td></td>
<td>2009 c 2010 d 2011 e</td>
<td>2009 c 2010 d 2011 e</td>
</tr>
<tr>
<td>Alabama</td>
<td>67.98 68.01 68.54</td>
<td>77.59 77.61 77.98</td>
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<td>Alaska</td>
<td>50.53 51.43 50.00</td>
<td>65.37 66.00 65.00</td>
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<td>Arizona</td>
<td>65.77 65.75 65.85</td>
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(Continued)
2.C Other Programs: Medicaid

Table 2.C2—Federal medical assistance percentage and enhanced federal medical assistance percentage, by state or other area, 2009–2011—Continued

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SOURCE: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

a. Section 1905(b) of the Social Security Act (the Act) specifies the method to be used to compute the federal medical assistance percentage. From this section the following formula is derived: \( N = 3\text{-year average national per capita personal income; } S = 3\text{-year average state per capita personal income. Federal medical assistance percentage: State share } = \left(\frac{S^2}{N^2}\right) \times 45 \text{ or } \left(\frac{45}{N^2}\right) \times S^2; \text{ Federal share } = 100 – \text{ state share with 50–83 percent limits.}

b. This is the Title XXI enhanced federal medical assistance percentage rate specified in section 2105(b) of the Act. The enhanced federal medical assistance percentage cannot exceed 85 percent.


f. The values for the District of Columbia (DC) in the table were set for the state plan under titles XIX and XXI and for capitation payments and Disproportionate Share Hospital (DSH) allotments under those titles. For other purposes, including programs remaining in Title IV of the Act, the percentage for DC is 50.00.

g. For purposes of section 1118 of the Social Security Act, the federal medical assistance percentage used under titles I, X, XIV, and XVI, and part A of title IV will be 75 percent.

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